



CONGRESS OF CALIFORNIA SENIORS

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May 25, 2010

The Honorable David Maxwell-Jolly, Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Dear Director Maxwell-Jolly:

I am writing in response to your invitation for comment from stakeholders on the DHCS draft implementation plan for California's 2010 1115 Waiver Renewal. As you know, on behalf of the Congress of California Seniors I have been an observer and provided public comment at all the Stakeholder Workgroup meetings on the 1115 Waiver Renewal as well as the task force meetings of the SPD and Dual Eligibles Task Forces. I greatly appreciate the time and materials that you and the staff of DHCS have committed to this effort.

I have also been an active participant in several working groups of various stakeholder coalitions which have met regularly throughout this process. These groups have brought together advocates for people with disabilities, providers of home and community based services, advocates for low income Californians, for seniors and for health care consumers. A number of us are working to craft a collective commentary on the draft implementation plan. This letter reflects only the views of the Congress of California Seniors, although we share a number of these views with other consumer advocates.

Background

The stakeholder process associated with the 2010 renewal of California's 1115 Medi-Cal waiver has separated consideration of the SPD population between those who are eligible for Medi-Cal only and those who are dually eligible for Medicare and Medi-Cal. We understand that Medicare rules make treatment of these groups different because of the Medicare requirement of choice of providers. We, however, do not make that distinction and treat the entire population in the same way, recognizing that the source of coverage funding is the only significant difference between the two groups. In this letter, I refer to the entire population using the acronym "SPD".

Further, the Congress of California Seniors believes that both groups should have a choice between fee-for-service and managed care under the new waiver.

This idea of choice was one of the core principles of health care reform nationally and at the state level in 2007, and we support that principle. We certainly acknowledge that many people in this high-user population would benefit from care coordination and coordination of medical care with community based psycho-social services, but some may prefer to receive care under a coordinated fee-for-service arrangement. Others may not be able to find the most appropriate provider(s) in a managed care system. Given that most of these individuals have an established relationship with a provider (or multiple providers) we think it is wrong to force them to sever those relationships and enter a managed care system which doesn't allow access to their existing provider(s) and allow choice of the most appropriate providers.

We recognize that one of the goals of transitioning SPDs from fee-for-service into managed care is to lower the increase in costs of serving this population. We strongly believe that any savings resulting from the shift to managed care of SPDs should be reinvested back into the care and services available to this population, including in home and community based supportive services and restoration of the full range of services under Medi-Cal that were in place in 2008.

We recognize that the State is likely to continue pursuing a policy of mandating non-dual SPDs into managed care. In that event, we have the following recommendations on how that process should proceed.

Plan Readiness and Accessibility

Before anyone is mandated into a managed care system, the state should promulgate and use a managed care plan readiness tool based on standards developed with input and approval of SPD consumers. The standards should specify a ratio of primary care providers to enrollees at a level appropriate for this population (or varied physician/client ratios based on patient acuity). Plans must demonstrate that providers have physical access, language skills, cultural competence, expertise, and experience to address the myriad needs of the SPD population. Plans should demonstrate that they have a dementia-capable workforce. They should be able to demonstrate financial capacity to serve as a risk bearing entity. The readiness tool should have a systematic means of measuring access to specialists and specialty care. The state should certify that any plan that enrolls SPDs meets the standards of readiness.

Timeline, Continuity of Care and Transitions

The timeline laid out by the DHCS proposal is inadequate and may set up a care management crisis similar to what occurred with the roll out of the Medicare Part D program. We believe the Department, working with consumer advocates and plans, should develop a specific plan of phased geographic transition that also recognizes patient acuity and complexity. The plan should work to transition

those individuals with the least complex set of providers or diagnoses first, those with moderately complex treatment needs next and those most complex or terminally ill patients last. Phasing of transitions should also be based on the best match of existing providers being included in managed care networks. It should proceed first in counties with the most developed and successful managed care systems for non SPD populations.

We believe there must be specific and carefully developed procedures for transitioning an SPD from existing providers into managed care based on acuity. Existing law governing commercial managed care plans requires a transition period of 12 or months or more. It covers a generally healthier population with fewer conditions and fewer providers than the SPD population. We believe that any SPD consumer with multiple providers (three or more) and/or multiple chronic conditions should be given 24 months to transition, with active engagement of the plan to facilitate a smooth transition. Any person with fewer than three providers or no chronic conditions should be given a full 12 months to transition.

The state should designate and contract with organizations (which may or may not be a managed care plan) to undertake transition and on-going enrollment. Plans should provide consumer-friendly, readily accessible information and education to facilitate all transitions and enrollment. Consumers should be given a choice of at least two alternative plans in which to enroll (not just at the option of counties). Under no circumstances should there be wholesale default assignment of consumers who fail to make a choice. There should be one-on-one assistance in transitioning care from existing providers for every transitioning or new enrollee.

Before any SPDs are mandatorily enrolled in managed care, there must be a comprehensive and aggressive education/outreach campaign to educate the population about the changes, when the changes will take place, and how beneficiaries can receive assistance and resolve problems. The education and outreach program should explain to potential enrollees how to prepare for the transition, explain what the delivery system choices are, how to make a list of conditions and a list of current providers and types of care needed, how to assess choices and how to influence the choice. Potential enrollees must have active, individual assistance in navigating the transition and managed care system.

We also believe the following must occur:

- The state should review and approve any outreach, enrollment or marketing materials by a plan prior to publication or distribution.
- The state must be responsible to ensure contact with every potential enrollee, and closely monitor the transition process.
- No SPD considered medically fragile or with known cognitive or mental impairments or serious substance abuse issues should be placed in a plan

unless personal contact has been made and an assessment (see below) has been completed.

- The state should be responsible for insuring that a potential managed care plan has capacity to meet the specific care needs of the potential enrollee and should slow or suspend enrollment if the appropriate care cannot be guaranteed.
- The state should provide the managed care plan with information about the enrollee, including a list of Medi-Cal services received, providers, and homecare and personal services, ADHC, and other HCBS services.
- There must be a specific procedure in place allowing an enrollee to disenroll (opt out) or switch to another plan without interruption of care and services, including access to fee-for-service care as necessary.
- Plans must have accessible information available to enrollees about the disenrollment process and follow up with enrollees to determine the reason(s) for disenrollment and report this information to the state.

Individual, Client-Centered Assessment and Care Planning

No SPD should be placed in a managed care system until a thorough, individualized assessment of the patient's medical, behavioral, and psycho-social needs has been completed and a plan of care developed. At a minimum, every SPD enrolled in a managed care system must be assessed within 30 days of enrollment. The assessment must be conducted and reviewed with a multi-disciplinary care team. It should be used as the basis for an individual plan of care and support services. There must be a system of accountability that ensures that individuals are actually linked to and receive needed services. Members of the team should be appropriately licensed, qualified and trained to do the assessment and create the plan.

There should be regular reassessments based on changes in health status (and more frequently as health status declines). There should be intensive assessment, care planning and coordination at the time of any hospital or nursing home admission and discharge. Family and other home caregivers should be involved in the assessment and care plan development.

Inclusion of Long Term Care Supportive Services, Home and Community Services, and System Adequacy

In addition to medical, dental and other health care services (below), care plans must include (as appropriate)

- Case management
- In-home supportive services
- Adult Day Health Care
- PACE
- HCBS waiver programs

- Independent Living Centers, Assisted living facilities, RCFEs
- Caregiver support (CRCs, ADCRCs, Respite care)
- Home health agencies
- Personal care services
- Skilled nursing facilities
- Regional Centers
- Affordable housing agencies
- Home modification
- Accessible transportation
- Nutrition support (food assistance, home delivered and congregate meals)
- Health education programs
- Legal services
- Socialization

Plans should be required to cover providers outside the area, or arrange and authorize regular referrals to specialists or specialty care outside the network. On an annual basis, plans should demonstrate to the state the availability and adequacy of the following services, in addition to the home and community based services by county in which they operate:

- Hospital services
- Laboratory services
- Primary care physician services
- Physician specialists and specialty services
- Prescription drugs and pharmacy services
- Behavioral health providers
- Substance abuse treatment
- Vision care/optical labs
- Dental care providers
- Audiology services
- Podiatry services
- Physical, occupational and speech therapy
- Dietitians/nutritionists
- Prevention/wellness/education programs
- Prosthetics and orthotics
- Durable medical equipment and devices
- Medical supplies

Notwithstanding current practice and funding arrangements, these services should not be carved out nor excluded from coverage under a managed care plan for SPDs. The rates negotiated between the state and Medi-Cal managed care plans should be set annually, be built on actuarial soundness, and should encompass the above set of services/benefits.

Accountability

Before mandatory enrollment of SPDs begins, plans must demonstrate that they have in place a mechanism for input/oversight from the community in which it operates as well as from the SPD population. Our preference is for organized delivery systems with a publicly elected board (or one appointed by those with public accountability). The oversight mechanism must have one or more local advisory committees familiar with the delivery of care and community based resources in the local area.

Plans must conduct regular case conferences involving all providers (including psycho-social and supportive services), patients, and family or other caregivers.

The Department should collect information to demonstrate improvements in the quality of care and outcomes as compared to fee-for-service Medi-Cal. The information should go beyond existing HEDIS data which fails to capture information for elderly patients. It should describe patterns of practice, utilization, health outcomes (including management of chronic conditions), consumer satisfaction, rates of enrollment, grievances, and other data. It should cover treatment planning, timeliness, access to specialty care and system wide accessibility. These data should be incorporated into an annual report to the Legislature and the public. To further ensure a policy oversight role for the Legislature, we believe any provisions mandating seniors and persons with disabilities into managed/coordinated care settings should have a legislated sunset date which forces the state and plans to demonstrate that the aims of the 1115 Waiver have been met and that data demonstrate the care systems meet or exceed the performance of those under fee for service. While the new waiver will have a specific life, we want the Legislature to have an active, timely review of its performance. There must be on-going legislative oversight.

The state should also develop a system of annual inspections and enforcement of all standards that include public reports, fines, sanctions, and suspension of licensure for failure to meet the standards.

Accessibility

The plan readiness tool (described above) must detail minimum requirements for plans to insure access to persons with disabilities and demonstrate compliance with all federal and state disability rights laws. Plans must demonstrate that they (and all contracted providers) can provide care and services that are physically and programmatically accessible to all persons with the following disabilities:

- Cognitive/Developmental
- Hearing
- Vision
- Mobility
- Language

Cultural

In addition,

- Plans must be able to demonstrate capacity to provide members with current information on accessibility of all plan providers and contracted providers outside the plan and any accommodations the plan providers will undertake.
- Communication access resources must be available at all points of contact and be a part of the general cost of provision of services.
- Plans must provide plain language information to SPD enrollees about their right to accessible care, including care in the language spoken.
- The state should establish access accountability advisory committee(s) and make public any audits regarding access.

Consumer Protections

The Knox Keene Act covering commercial plans includes important consumer protections which should be extended to cover any organized system of care into which SPDs are mandatorily enrolled. These include, among others:

- Right to a second opinion
- Right to an independent medical review
- Standards for utilization review
- Publicly available criteria for denial of care
- Right to sue
- Timely access standards (which may need to be higher for SPDs)
- Language access
- Availability of a help line
- Standards for grievances and appeals
- Published drug formulary, with brand name drugs where no generic exists
- Reasonable person standard for access to emergency care
- Application to all contracting providers

Each plan should have an established grievance process that is clearly explained and available to enrollees and a mechanism to monitor the grievance system and the timeliness of handling grievances. Additionally, the state or counties must have an Ombudsman service available to enrollees to assist with enrollment, navigation of services, grievances, and hearing requests.

The state should empower a stakeholder review panel to determine the adequacy of all these protections for a frail, high-user SPD population and the consumer protection standards for enrollees in Medi-Cal managed care should be placed in statute.

The existing rate structure for fee-for-service Medi-Cal services has been so low that many enrollees have been challenged to find providers...especially specialists or specialty care providers. Because rate adequacy is essential for

quality managed care, we also believe there should be a public, transparent process with consumer input in setting rates for Medi-Cal managed care plans.

The state should empower a stakeholder review panel to set standards for financial risk and to develop a rate methodology. No organized system of care should be allowed to accept financial risk without demonstrating adequate financial capacity to provide contracted care. The state should contract with experts to assist the panel to develop a methodology that assures adequate access and appropriate incentives. It should consider different rates for different populations based on complexity and acuity.

Summary

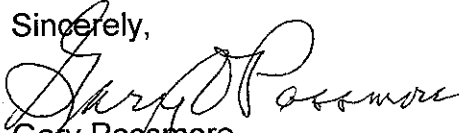
The Congress of California Seniors believes that a well planned transition to managed care for seniors and persons with disabilities can be accomplished in a relatively short period of time, perhaps thirty months after approval of the waiver by CMS. This would allow six months for development of standards, education of potential enrollees, and stakeholder review of Knox-Keene and other consumer protection provisions. There would still be twenty-four months to complete a careful and client-sensitive transition into those plans which are most ready. We also believe the DHCS implementation plan needs to further address actions which would allow SPDs in counties where no plan exists to have access to coordinated care through a health care home. Accomplishing this will probably require the balance of time covered by the 2010 waiver, perhaps longer.

However it is phased in, the transition to managed care must recognize the complex health care and psycho-social needs of this vulnerable population. It is essential that, before transition to managed care occurs, the state insure stakeholders and enrollees that the managed care systems meet essential minimum standards for quality coordinated care.

We also believe that very good, comprehensive care and support can minimize public spending, especially if the system gives long-overdue attention to use of electronic records, duplication of service and unnecessary care, adverse events and health acquired infections throughout the health care system. And we must imbue the system with an understanding that avoiding unnecessary acute and long term institutional care saves money and usually means better care.

We hope this letter helps inform your work.

Sincerely,


Gary Passmore
Director
Congress of California Seniors